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Benefits and Cost-Sharing for Working People with Disabilities in Medicaid and the Marketplace

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Executive Summary

Access to affordable health insurance with adequate coverage of key benefits is essential to the ability of people with disabilities to seek and maintain employment. As their income fluctuates, people may migrate between Medicaid and Marketplace coverage, and because different rules apply in these two programs, they may face changes in their benefits and out-of-pocket responsibilities as a consequence. This issue brief uses hypothetical examples of working people with disabilities to illustrate the experiences they might have with Medicaid and Marketplace coverage in four states (California, Kentucky, New Jersey, and Ohio), with a focus on benefits that are typically important to people with disabilities.

The profiles include:

- Susan, a 21 year old woman, with mild cerebral palsy (CP) who is working part-time while completing her Bachelor's degree;
- John, a 35 year old construction worker, with clinical depression; and
- Mary, a 40 year old woman who works at a fast food restaurant and recently was diagnosed with multiple sclerosis.

Key themes emerging from this analysis include the following:

- **Due to mental health parity requirements, Medicaid benefits for newly eligible adults may include more extensive mental health and substance use treatment services, unless states also modify their Medicaid state plan benefits to reflect the full extent of required coverage for new adults.** These differences are likely to affect John as he seeks treatment for clinical depression. For example, while outpatient mental health, clinic, and case management services are available under both New Jersey's Medicaid state plan and its new adult alternative benefit plan (ABP), New Jersey's ABP also has more extensive mental health and substance use treatment services and includes more intensive care coordination and treatment services, such behavioral health homes and program of assertive community treatment services, which might be appropriate for John, depending on his needs.

- **Prescription drug coverage is likely to vary between Medicaid and Marketplace Qualified Health Plans (QHPs) as well as among QHPs within a state.** Because Susan takes prescription drugs to control the muscle spasticity resulting from CP, she will want to carefully evaluate the different Marketplace QHP formularies to see if the drugs that she currently is prescribed are covered when she takes a higher paying job and transitions from Medicaid to Marketplace coverage.
- **Within a benefit category, Marketplace QHP coverage of specific services, such as rehabilitative and habilitative services, may differ from Medicaid coverage and may be subject to different utilization limits than apply in Medicaid in some states. Coverage of specific services also may vary among QHPs within a state.** For example, if Mary seeks physical therapy services to address the effects of MS, she would have similar coverage under Ohio’s new adult ABP and state plan benefits, which both cover 30 physical therapy visits per year, with additional visits approved through prior authorization. After Mary transitions to Marketplace coverage when her earnings increase, she would have somewhat less generous coverage under the Ohio benchmark QHP, which covers 20 physical therapy visits per year.
- **Coverage of long-term services and supports may be more extensive in Medicaid than in Marketplace QHPs.** For example, while personal care services are optional in Medicaid, New Jersey includes them in its Medicaid state plan and new adult ABP. Once Susan transitions to Marketplace coverage, personal care services are not included in New Jersey’s benchmark QHP.
- **Provider networks may differ between Medicaid and Marketplace QHPs.** If it is important for John to remain with the same psychiatrist who has been treating him, then he will want to choose a QHP in which that physician participates when he moves from Medicaid to Marketplace coverage.
- **Beneficiaries are likely to experience higher out-of-pocket costs in Marketplace QHPs than in Medicaid.** While Medicaid premiums and cost-sharing are imposed at state option and limited to certain populations, Marketplace QHPs have premiums that are limited based on income, ranging from 2% of income for those with incomes up to 133% FPL to 9.5% of income for those with incomes from 300-400% FPL in 2014. California has standardized cost-sharing amounts for all its Marketplace plans in the same metal tier, while cost-sharing varies among QHPs in the other states in this analysis.

Looking ahead, Medicaid is likely to remain an important source of coverage for working people with disabilities, and the ACA’s Medicaid expansion and new Marketplace QHPs will provide greater access to affordable coverage for this population as their incomes increase. Understanding experiences that working people with various disabilities are likely to encounter can help inform policymakers’ choices in designing Medicaid and Marketplace benefit packages and cost-sharing rules.

Introduction

Nearly 27% of working-age people with disabilities were employed in 2013, and an additional almost 15% were unemployed but actively seeking work.¹ Programs such as the Social Security Administration's Ticket to Work² for people who receive Social Security Disability Insurance or Supplemental Security Income benefits, as well as state vocational rehabilitation agencies,³ offer job search, training, and other services to support the employment of people with disabilities. However, access to affordable health insurance that meets their needs for medical and long-term services and supports (LTSS) remains essential to the ability of people with disabilities to seek and maintain employment.

Medicaid has long been an important source of health insurance for people with disabilities. The Affordable Care Act (ACA) created new coverage options, effective January 1, 2014, that benefit people with and without disabilities.⁴ The health reform law expanded Medicaid to adults with incomes up to 138% of the federal poverty level (FPL, \$16,105 per year for an individual in 2014), many of whom previously were ineligible for coverage. (Due to the Supreme Court's ruling on the ACA, the Medicaid expansion is effectively a state option.⁵) The Medicaid expansion establishes a uniform level of financial eligibility, which promotes continuity of coverage when workers change jobs or move interstate, to the extent that states have expanded coverage. In addition, there are several optional coverage groups that allow working people with disabilities to buy in to Medicaid coverage by paying a premium.

The ACA also provides for qualified health plans (QHPs) that people without access to employer-sponsored or other coverage that meets federal minimum standards can purchase through new health insurance Marketplaces. QHP benefit packages are based on a benchmark commercial insurance plan and therefore are similar to employer-sponsored insurance. To make Marketplace coverage more affordable, the ACA provides for premium tax credits for people with incomes from 100% to 400% FPL (\$11,670 to \$46,680 per year for an individual in 2014) and cost-sharing reductions for people with incomes from 100% to 250% FPL (\$11,670 to \$29,175 per year for an individual in 2014). In addition, the ACA includes private insurance market reforms that improve access to coverage for people with disabilities. These include a provision for guaranteed issue, which prevents health insurers from denying coverage to people for any reason, including pre-existing conditions, and a provision requiring community rating, which allows health plans to vary premiums based only on age, geographic area, tobacco use, and number of family members, and thereby prohibits plans from charging higher premiums based on health status or gender.

As people's incomes fluctuate, they may move between Medicaid and Marketplace coverage and, because different rules apply to the two programs, face changes in their benefits and out-of-pocket costs as a consequence. This issue brief uses hypothetical examples of working people with disabilities to illustrate the kinds of experiences they are likely to have with Medicaid and Marketplace coverage in four states – California, Kentucky, New Jersey, and Ohio – with a focus on benefits typically important to people with disabilities, including mental health and substance use treatment services, prescription drugs, rehabilitative and habilitative services and devices, and LTSS. All four states have implemented the ACA's Medicaid expansion. However, they have made different decisions about how to design their Medicaid benefit packages for newly eligible adults, and how to set up and administer the Marketplace that serves their state. Key themes identified from this analysis reveal the potential impact of various state and plan decisions on working people with disabilities and can help inform policymakers' future choices in designing Medicaid and Marketplace benefit packages and cost-sharing rules.

Background

MEDICAID AND MARKETPLACE BENEFITS

Federal law requires all states that participate in the Medicaid program to cover certain benefits and also allows states to cover additional optional benefits.⁶ Examples of mandatory state plan benefits include inpatient hospitalization and outpatient physician services; examples of optional state plan benefits include prescription drugs (which all states currently cover) and many LTSS important to people with disabilities, such as personal care services. As a result of the broad state flexibility to define Medicaid benefits under federal law, the specific services that states cover (outside the federally required services) vary widely.

Under federal law, states also have the flexibility to offer different Medicaid benefit packages to different populations, provided that certain minimum benefits are covered. This is accomplished by designing an alternative benefit plan (ABP, previously called “benchmark coverage”) based on one of several commercial insurance plans or on a benefit package approved by the Health and Human Services Secretary.⁷ Prior to the ACA, only a few states took up the ABP option. However, the ACA requires that adults newly eligible through the Medicaid expansion receive an ABP. An exception to this rule is that beneficiaries who are considered medically frail must have access to all the benefits contained in the Medicaid state plan package, to the extent that it differs from the new adult ABP. Unlike Medicaid state plan benefits, ABPs must cover the 10 categories of essential health benefits (EHBs) set out in the ACA. ABPs also must provide parity in coverage of physical and mental health benefits and include certain traditional Medicaid services, such as non-emergency medical transportation and federally qualified health center services.

Beyond these minimum requirements, states can choose the underlying benchmark plan on which an ABP is based and decide whether to align the contents of their new adult ABP with their Medicaid state plan benefit package. If the state plan and new adult ABP benefits are fully aligned, all Medicaid beneficiaries in the state have access to the same set of benefits. If states do not align the two benefit packages, then beneficiaries may have access to different sets of services if they shift from the new adult group to a pre-ACA coverage group or vice versa when their income changes. For example, certain LTSS may be available through the Medicaid state plan benefit package but not included in the new adult ABP, depending on the state’s choices. At the same time, even if states base their new adult ABP on their state plan benefit package, the new adult ABP may include more benefits, such as additional behavioral health and preventive services, unless states also add these services to their state plan benefit packages. This result could arise because the ACA’s EHB and mental health parity requirements apply to ABPs but not to Medicaid state plan benefits. (However, if a state opts to deliver Medicaid state plan benefits through managed care organizations (MCOs), mental health parity is required for Medicaid MCOs, to the extent that the MCO’s benefit package includes both physical and mental health services.)

Marketplace QHP and Medicaid new adult ABP benefit packages both must include the 10 categories of EHBs. However, the specific services that QHPs cover within an EHB category may differ from those covered under the new adult ABP because the ACA allows states to base their QHPs and new adult ABP on different underlying benchmark plans. The ACA also allows for benefit substitution within an EHB category as long as the substitute benefits are actuarially equivalent to those they replaced. Thus, there are likely to be differences in the coverage of specific services among different QHPs, and also between QHPs and Medicaid. Key

differences between Medicaid state plans, ABPs, and Marketplace QHPs in coverage of benefits that are important to people with disabilities are summarized in Table 1 below.

Table 1: Key Differences in Required Benefits in Medicaid State Plans, ABPs, and Marketplace QHPs

Benefit Type	Medicaid State Plan	Medicaid New Adult ABP	Marketplace QHP
Mental health and substance use treatment services	Available through some required categories (e.g., physician services); also provided through optional categories (e.g., other rehabilitative services); Medicaid only covers inpatient mental health services in an IMD up to age 21 or over age 65	Required as part of EHB; Medicaid only covers inpatient mental health services in an IMD up to age 21 or over age 65	Required as part of EHB
Mental health parity	Optional (states may cover mental health benefits in a different amount, duration and scope than physical health benefits); however, if state delivers benefits through a managed care organization (MCO), mental health parity is required for MCOs (to the extent that both physical and mental health services are included in the MCO's benefit package)	Required (however, Medicaid IMD payment exclusion still applies)	Required
Prescription drugs	Optional (all states presently cover; must cover all FDA-approved drugs whose manufacturers have entered into rebate agreement)	Required as part of EHB (must cover at least 1 drug per class)	Required as part of EHB (must cover at least 1 drug per class)
Rehabilitative services and devices	Medical equipment, supplies, and appliances are part of the required home health services for people who qualify for nursing facility services; otherwise optional (e.g., physical therapy and related services, prosthetic devices)	Required as part of EHB	Required as part of EHB
Habilitative services	Optional (e.g., § 1915(i) state plan HCBS)	Required as part of EHB (may be defined by state if not included in EHB benchmark)	Required as part of EHB (may be defined by health plan or state if not included in EHB benchmark)
Long-term services and supports	Nursing facility services and home health services for people who qualify for nursing facility services are required; other LTSS are optional (e.g., personal care, case management, etc.)	Optional (unless included in ABP or EHB benchmark plan coverage)	Optional (unless included in EHB benchmark plan coverage)

MEDICAID AND MARKETPLACE COST-SHARING

Federal law permits states to impose premiums and cost-sharing on certain Medicaid beneficiaries subject to specified limits and exemptions.⁸ Medicaid premiums and cost-sharing are limited to 5% of family income, calculated on a quarterly or monthly basis, at state option. Premiums generally are not permitted for Medicaid beneficiaries with incomes below 150% FPL (\$17,505 for an individual in 2014), but can be imposed at state option on some populations with incomes above that level. There also are several optional Medicaid eligibility groups for working people with disabilities that enable such individuals to “buy in” to Medicaid coverage by paying a sliding-scale premium based on income.

Medicaid co-payments also are permitted for some populations at state option. Co-payments must be “nominal” for beneficiaries with incomes below the federal poverty level and are subject to federal maximums for beneficiaries with higher incomes. For example, in 2014, the maximum co-payment for an outpatient service for people with income at or below poverty is \$4, and co-payments for outpatient services are limited to 10% of the agency’s cost for those with incomes between 101-150% FPL, and to 20% of the agency’s cost for those with more income. The maximum co-payment for preferred prescription drugs for all beneficiaries in 2014 is \$4; for non-preferred drugs, the maximum co-payment is \$8 for people with incomes at or below 150% FPL, and 20% of the agency’s cost for those with more income. State Medicaid programs must cover preventive services without cost-sharing, and providers cannot deny services for Medicaid beneficiaries’ failure to pay a co-payment for people with incomes below poverty.

In the Marketplace, the ACA limits QHP premium costs, ranging from 2% of enrollee income for those up to 133% FPL to 9.5% of income for those from 300-400% FPL in 2014. Marketplace enrollees with incomes between 100% and 400% FPL qualify for advance payment of tax credits to subsidize premium costs that exceed this limit. In addition to premiums, QHPs can charge deductibles and co-payments. Enrollees with incomes between 100% and 250% FPL qualify for cost-sharing reductions to limit their out-of-pocket costs. As in Medicaid, Marketplace QHPs must cover preventive services without cost-sharing. Key differences in cost-sharing between Medicaid state plans, ABPs, and Marketplace QHPs are summarized in Table 2 below.

Table 2: Key Differences in Cost-Sharing in Medicaid State Plan, ABPs, and Marketplace QHPs

	Medicaid State Plan	Medicaid New Adult ABP	Marketplace QHP
Premiums	Not permitted for people with incomes below 150% FPL; permitted for certain coverage groups above 150% FPL; total premiums and cost-sharing limited to 5% beneficiary income	Same as state plan	Limited based on enrollee income: ranging from 2% of income for those up to 133% FPL to 9.5% of income for those from 300-400% FPL in 2014; advance payment of premium tax credits available for people between 100-400% FPL
Cost-Sharing	Permitted for certain coverage groups and services; must be nominal for people with incomes below poverty and subject to federal maximums for people above poverty	Same as state plan	Enrollee cost-sharing is limited to 6% of allowable costs of benefits for people with incomes between 100-150% FPL, 13% for people between 150-200% FPL, and 27% for people between 200-250% FPL

MARKETPLACE STRUCTURE AND ADMINISTRATION

The ACA gives states the option to establish their own Marketplace. State-based Marketplaces can be active purchasers of QHPs, regulating which plans can be offered for purchase. Alternatively, state-based Marketplaces can act simply as clearinghouses, allowing any issuer that wishes to offer a plan on the Marketplace to do so.

The ACA provides for a federally facilitated Marketplace (FFM) as a default in states that elect not to establish their own Marketplace. States also may choose to administer a Marketplace in partnership with the federal government by assuming control over the QHP administration and/or consumer assistance functions.

Hypothetical Experiences of Working People with Disabilities

PROJECT OVERVIEW

In light of the varied requirements and flexibilities pertaining to the design of benefit packages and to cost-sharing amounts in Medicaid and the Marketplace, and to illustrate the impact of different state policy choices on working people with disabilities, this issue brief considers the rules as they might affect representative individuals in different situations. The rest of this paper presents three profiles of hypothetical working people with disabilities and examines how their benefits and cost-sharing obligations may differ as they move between Medicaid state plan and new adult ABP coverage and between Medicaid and Marketplace QHPs. The analysis focuses on selected categories of benefits that are important to many people with disabilities, including mental health and substance use treatment services, prescription drugs, rehabilitative and habilitative services and devices, and LTSS.

The analysis considers the benefits and cost-sharing rules that apply to newly eligible adults in Medicaid programs in four selected states. It is important to note that if an individual who is eligible under the ACA's expansion meets the definition of "medically frail" or also qualifies for Medicaid through a disability-related (non-MAGI) eligibility pathway, that individual must have access to all Medicaid state plan benefits, to the extent that state plan benefits may differ from those in the state's new adult ABP. The analysis also considers the benefits and cost-sharing rules in representative QHPs in the four states' Marketplaces.

The states included in this analysis are California, Kentucky, New Jersey, and Ohio. These states, all of which are implementing the ACA's Medicaid expansion in 2014, were selected to illustrate different state policy choices about aligning Medicaid state plan benefits and new adult ABPs and about whether to operate a state-based or partnership Marketplace or to default to the FFM. This brief relies on Medicaid benefit and cost-sharing information from current state plans or applicable § 1115 demonstration waivers, and on states' new adult ABP state plan amendments as approved by CMS. Benefit information for Marketplace QHPs is based on the summary of benefits for the Marketplace benchmark plan selected by the state. All QHPs must have benefit packages that are actuarially equivalent to the benchmark plan, so the benchmark plan coverage can be considered representative of what a person would find in a Marketplace QHP. Cost-sharing information for Marketplace QHPs is based on an actual 2014 silver-level plan considered to be representative in each state, with premium tax credits determined using the Kaiser Family Foundation's subsidy calculator.⁹

It also is important to note that the actual coverage of specific services depends on an individual’s health condition, the recommendation(s) of a treating provider, and the state’s Medicaid medical necessity criteria or the applicable QHP coverage criteria. Also, this analysis is based on general language about covered categories of benefits in the sources described above; often, it is not possible to determine whether a specific service or item is covered by a plan until an actual claim is submitted. While the QHP benchmark plan used in this analysis is representative of what Marketplace QHPs cover, as noted above, plans may substitute actuarially equivalent benefits within the same EHB category. Therefore, the QHP coverage described in this brief is illustrative and not necessarily exactly what is available in all Marketplace QHPs in that state.

Table 3 summarizes the key Medicaid state plan and ABP benefits and Marketplace design choices among the states selected for this analysis. More detailed information about benefits and cost-sharing in each state’s Medicaid state plan and new adult ABP and representative Marketplace QHP is included in Appendix 1 and the methodology used to select the QHPs for the cost-sharing comparisons is included in Appendix 2.

Table 3: Key Characteristics of Selected States’ Medicaid Benefits and Marketplaces

State	Alignment of New Adult ABP with Medicaid State Plan Benefits (do new adult ABP and Medicaid state plan cover same benefits?)	Type of Marketplace
California	Aligned, but beneficiaries must meet medically frail criteria to access LTSS	State-based, active purchaser model; standardized deductibles, out-of-pocket maximums, and co-payments for all QHPs within same metal tier
Kentucky	Aligned	State-based, clearinghouse model
New Jersey	Not aligned - ABP offers additional behavioral health benefits and does not include certain LTSS	FFM
Ohio	Aligned except that ABP eliminates state plan utilization limits for certain behavioral health services	FFM

PROFILE SUMMARIES

Summaries of the three hypothetical profiles of working people with disabilities used in this analysis are presented below. The full profiles are included in Appendix 3.

HYPOTHETICAL 1: SUSAN, AGE 21, DIAGNOSED WITH MILD CEREBRAL PALSY (CP)

Susan recently completed community college and transferred to a four-year college to complete her Bachelor’s degree. She lives on her own and works 25 hours per week as a cashier, earning \$8.25 per hour. Her state has implemented the ACA’s Medicaid expansion, and her annual earnings of \$10,725, or about 92% of the federal poverty level for a single adult in 2014, make her eligible for Medicaid in 2014. Susan is subsequently offered a job as a bookkeeper during her senior year of college. When she changes jobs, she continues working 25 hours

per week, but earns \$13 per hour. Her new annual earnings of \$16,900, or approximately 145% FPL in 2014, make her eligible for Marketplace coverage with premium tax credits and cost-sharing reductions.

Susan's needs for acute physical health and preventive services are the same as those of other, healthy young adults. She also has some additional medical needs associated with her CP diagnosis. Susan is able to walk but uses crutches or a power scooter when she travels significant distances, including getting around campus. Because Susan's fine motor skills are mildly impaired, her family sometimes helped her button or tie clothing, prepare meals and do laundry when she was living at home. Susan had no plan for seeking assistance with her personal care needs when she went away to college, so they will likely be unmet, or performed to the best of her ability, without formal personal care services in place. She receives physical therapy twice a month to manage contractures stemming from muscle spasticity, and her physician believes she would benefit from weekly physical therapy and monthly occupational therapy to improve her fine motor skills. She takes prescription medication to control muscle spasticity, which is a common condition secondary to CP. While she is not currently in treatment for mental health issues, Susan was bullied in school because of her gait and use of crutches. She may have undiagnosed mild depression and/or anxiety as a result and might benefit from mental health diagnostic services, and if warranted, treatment.

HYPOTHETICAL 2: JOHN, AGE 35, DIAGNOSED WITH CLINICAL DEPRESSION

John is a high school graduate with a limited work history as a seasonal day laborer for a local construction company. In three of the last five years, he earned approximately \$15,000 per year, or about 129% FPL for a single adult in 2014. John's state has implemented the ACA's Medicaid expansion, and he is eligible for Medicaid in 2014. John was recently offered a year-round job as an assistant to an auto mechanic, earning \$8.15/hour for a 40-hour work week. If he takes this job, John would make \$16,952 a year, or about 145% FPL in 2014 and will become eligible for Marketplace coverage with premium tax credits and cost-sharing reductions.

John was first diagnosed with depression after a failed suicide attempt at age 32 when he was taken to the emergency department and involuntarily committed to inpatient treatment. John needs regular doctor appointments and takes a prescription anti-depressant medication. John's doctor has encouraged him to seek individual and group therapy, but he has been unable to follow up on this recommendation because he previously was uninsured and unable to pay out-of-pocket. He also could benefit from regular preventive health care services.

HYPOTHETICAL 3: MARY, AGE 40, DIAGNOSED WITH MULTIPLE SCLEROSIS

Mary finished high school but never went to college and currently works at a fast food restaurant. Mary works 30 hours a week at \$8.25 per hour, with annual earnings of approximately \$12,870, or about 110% FPL for a single adult in 2014. Her state has implemented the ACA's Medicaid expansion, and she is eligible for Medicaid in 2014. Mary then decides to take a job selling tickets at a movie theater on the weekends, where she will earn \$8.50 per hour. She will work 9 hours per week, earning \$3,978 per year and bringing her total annual income to \$16,848, or nearly 145% FPL in 2014. Once Mary takes her second job, she will become eligible for Marketplace coverage with tax credits and cost-sharing reductions.

Mary's lack of health insurance and limited income have made it difficult for her to afford basic preventive health care, such as annual physical examinations. In January 2014, she visited the emergency department after experiencing an extended bout of blurred vision and muscle weakness and subsequently was diagnosed with multiple sclerosis. Mary now sees a neurologist, who recommended that she begin receiving regular doses of an injectable drug to slow the progression of the disease. He also referred her to a physical therapist for regular treatment of her muscular weakness and ordered some additional tests to assess the extent of impairment in her vision and fine motor functioning.

Key Themes

Some common themes emerge from the analysis of Susan, John, and Mary's potential experiences as working people with disabilities seeking coverage under Medicaid and the Marketplace in selected states. As background, when analyzing the scope of benefits available through Medicaid in various states, it is important to remember that differences between Medicaid state plan and new adult ABP benefits reflect state choices about which optional Medicaid benefits to cover in their state plans and about whether to fully align their new adult ABP and their state plan benefits. In addition, determining the specifics about coverage of particular services in Marketplace QHPs is difficult without actually submitting a claim to the plan, as little detailed information is readily available from public sources. The key themes in this analysis include the following:

MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES

- **Because mental health parity requirements apply to Medicaid new adult ABPs, these plans may offer more extensive coverage of mental health and substance use treatment services than Medicaid state plan benefits do, unless states also modify their Medicaid state plan benefits to reflect the full extent of new adult ABP coverage (and unless state plan benefits are delivered through Medicaid MCOs, which must provide parity if both physical and mental health benefits are covered).**

EXAMPLE: SUSAN'S POTENTIAL EXPERIENCE IN CALIFORNIA AND NEW JERSEY

Susan might seek mental health diagnostic and treatment services for possible depression and/or anxiety stemming from the bullying she experienced as a result of her physical disabilities. If Susan lives in California, she has access to the same package of Medicaid mental health services regardless of whether she receives state plan benefits as a previously eligible adult or the ABP as a newly eligible adult. This is because California has elected to align its new adult ABP with its state plan benefits, both of which include outpatient mental health services, such as evaluation, therapy, and psychological testing. (Table 4)

Even though New Jersey has chosen not to align its Medicaid state plan benefits and its new adult ABP, Susan should be able to access the outpatient mental health services or mental health clinic services she might need through both the Medicaid state plan benefits package and the new adult ABP. Due to the mental health parity rules that apply to ABPs, New Jersey's new adult ABP has more extensive mental health and substance use treatment services than are covered in the Medicaid state plan. However, the additional services included in New Jersey's new adult ABP, such as behavioral health homes, mental health adult rehabilitation services (group homes), and program of assertive community treatment services, appear to be beyond what Susan might need at this time. (Table 8)

Once Susan accepts the position as a bookkeeper and her income increases, she would have access to outpatient mental health services through a Marketplace QHP. Based on the available information about QHP benefits, it is difficult to determine whether, in California and New Jersey, Marketplace coverage of mental health services would be more or less generous than, or comparable to, Medicaid coverage. California requires QHPs to cover outpatient mental health services for “severe mental illness” (Table 4), and a New Jersey state mandate requires insurers to cover services for “biologically based mental illness.” (Table 8)

EXAMPLE: JOHN’S POTENTIAL EXPERIENCE IN NEW JERSEY AND OHIO

Given John’s primary diagnosis of clinical depression, mental health treatment services will be important to support his ability to work. In contrast to Susan, John will likely be affected by the benefit differences between New Jersey’s Medicaid state plan and its new adult ABP, because his mental health treatment needs are more intensive. As noted earlier, New Jersey has chosen not to align its Medicaid state plan benefits with its new adult ABP, with the result that the new adult ABP has more extensive mental health and substance use treatment services (due to the mental health parity requirements). Outpatient mental health, clinic, and case management services are available under both New Jersey’s Medicaid state plan and the new adult ABP. In addition, New Jersey’s ABP includes more intensive care coordination and treatment services, such behavioral health homes and program of assertive community treatment services, which might be appropriate for John, depending on his needs. (Table 8)

If John lived in Ohio, he would have access to the same categories of mental health treatment services regardless of his Medicaid coverage group because the state has chosen to include all of its Medicaid state plan services in its new adult ABP. The mental health benefits in both packages include psychologist services, psychiatric clinical nurse specialists, behavioral health clinic services (including counseling, therapy, mental health assessment, pharmacologic management, partial hospitalization, crisis intervention, community psychiatric supportive treatment), and case management services. Ohio also has opted to include behavioral health home services for people with serious mental illness in both Medicaid packages. However, due to the mental health parity rules that apply to ABPs, Ohio has removed the Medicaid state plan utilization limits on mental health services from the ABP. Examples of utilization limits under Ohio’s state plan Medicaid benefits that do not apply to the ABP include a maximum of 52 hours per year of behavioral health counseling and therapy and a maximum of 30 cumulative hours per week of group and individual counseling and medical/somatic services. (Table 10)

Like Susan, when John moves from the new adult ABP to Marketplace coverage, he would continue to have access to mental health outpatient services through a QHP in Ohio. However, he would be subject to different utilization limits, as the benchmark plan for Ohio’s QHPs limits outpatient mental health services to 30 visits per year. (Table 10)

PRESCRIPTION DRUGS

- **Prescription drug coverage is likely to differ between Medicaid and Marketplace plans.** State Medicaid programs must cover all FDA-approved drugs whose manufacturers have entered into a rebate agreement with the state. By contrast, the EHB provisions of the ACA only require Marketplace QHPs’ formularies to include at least one drug per class. All four states included in this analysis chose to use the

same prescription drug formulary for their Medicaid state plan and new adult ABP. It is likely that QHPs will cover fewer drugs than Medicaid because of the different rules for QHPs. In addition, QHPs may have different preferred drug lists than state Medicaid programs do. Finally, prescription drug coverage is likely to vary among QHPs.

EXAMPLE: SUSAN, JOHN AND MARY’S POTENTIAL EXPERIENCES

Prescription drug coverage is important to all three representative people with disabilities, as Susan takes medication to help control the muscle spasticity that results from her cerebral palsy, John takes medication to treat his depression, and Mary relies on medication to address the effects of MS. California, Kentucky, New Jersey, and Ohio all have chosen to cover the same prescription drugs in their Medicaid state plan and new adult ABP, so if beneficiaries transition between Medicaid coverage groups in these states, their prescription drug coverage should not change. Kentucky and Ohio’s Medicaid programs use a preferred drug list, and some drugs may require prior authorization. (Tables 4, 6, 8, 10)

When Susan, John, or Mary transitions to a Marketplace QHP, they will want to carefully evaluate the different plan formularies to see if the drugs that they are currently prescribed are covered. Prescription drug coverage is likely to be an area of difference between Medicaid and the Marketplace because state Medicaid programs must cover all FDA-approved drugs whose manufacturers have entered into a rebate agreement, while Marketplace QHPs must cover at least one drug per class. In addition, coverage of specific drugs may vary among QHPs. As long as one drug per class is covered, not all drugs may be covered by a particular QHP. In addition, QHPs may assign drugs to different formulary tiers (e.g., preferred vs. non-preferred brand), which could affect out-of-pocket cost-sharing. (Tables 4, 6, 8, 10)

REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES

- **Marketplace QHP coverage of specific benefits within an EHB category, such as rehabilitative and habilitative services, may differ from Medicaid coverage of these services and may be subject to different utilization limits than under Medicaid in some states.** Coverage of specific services also may vary among QHPs in the same state.

EXAMPLE: SUSAN’S POTENTIAL EXPERIENCE IN CALIFORNIA AND NEW JERSEY

Durable Medical Equipment

Because Susan relies on crutches to ambulate short distances and a power scooter for longer distances as a result of cerebral palsy, her plan’s coverage of durable medical equipment will be important. As noted above, California has chosen to align its Medicaid state plan benefits with its new adult ABP, and durable medical equipment is covered under both, subject to prior authorization. Susan would need to look into whether the specific equipment that she needs would be covered, likely by submitting a claim. (Table 4)

By contrast, New Jersey’s Medicaid state plan benefits include durable medical equipment, but New Jersey’s new adult ABP does not, so this would be an area of difference in coverage for Susan, if she was eligible for Medicaid as a new adult, unless she meets the definition of “medically frail” in which case she could access the state plan benefits as a newly eligible adult. (Table 8)

Marketplace QHPs in both California and New Jersey cover durable medical equipment, subject to prior authorization (durable medical equipment also is a state mandated benefit for insurers in New Jersey). Again,

Susan would need to submit a claim to determine whether the specific equipment she needs would be covered by her particular QHP. (Tables 4 and 8)

Physical and occupational therapy

If Susan decides to continue or increase the physical and/or occupational therapy recommended by her doctor to address the effects of cerebral palsy, it appears that she would have access to these services in Medicaid and the Marketplace in both California and New Jersey, although perhaps subject to different utilization limits. Again, California's Medicaid state plan and new adult ABP services are aligned, and both include physical and occupational therapy services. In New Jersey, the Medicaid state plan benefit package includes physical and occupational therapy as rehabilitative services, while the new adult ABP covers these services for both rehabilitative and habilitative purposes. (Tables 4 and 8)

California Marketplace QHPs cover physical and occupational therapy as outpatient rehabilitative services, and they also cover habilitative services (which also are a state-mandated benefit in California). The New Jersey Marketplace benchmark QHP used in this analysis covers physical and occupational therapy for both rehabilitative and habilitative purposes but also includes a utilization limit of 30 visits per year. The coverage of physical and occupational therapy for habilitative purposes, as distinct from rehabilitative purposes, may be significant for Susan as rehabilitative services generally are provided to help people regain lost skills, while habilitative services focus on the acquisition of skills which are missing due to a disabling condition. (Tables 4 and 8)

EXAMPLE: MARY'S POTENTIAL EXPERIENCE IN KENTUCKY AND OHIO

Mary may seek physical therapy services to address the effects of MS. Kentucky has opted to align its new adult ABP with its Medicaid state plan benefits. Physical therapy is covered under both, limited to 20 visits per year, with prior authorization. In Ohio, Mary would have similar physical therapy coverage under that state's Medicaid program under the state plan or new adult ABP, although with different utilization limits as compared to Kentucky. Ohio's Medicaid state plan and new adult ABP both cover physical therapy at 30 visits per year, with additional visits approved through prior authorization. (Tables 6 and 10)

After Mary transitions to the Marketplace, Kentucky's QHP benchmark coverage for physical therapy is the same as under its Medicaid program, limited to 20 outpatient visits per year. The benchmark QHP plan for Ohio covers 20 physical therapy visits per year, so under that plan in the Marketplace, Mary would have somewhat less generous coverage than under Ohio Medicaid. (Tables 6 and 10)

LONG-TERM SERVICES AND SUPPORTS

- **Coverage of LTSS may be more extensive in Medicaid than in Marketplace QHPs.**

EXAMPLE: SUSAN'S POTENTIAL EXPERIENCE IN CALIFORNIA AND NEW JERSEY

If Susan decides to pursue personal care services for assistance with dressing and household activities once she is living alone, she might encounter coverage differences when she moves from Medicaid to the Marketplace. Personal care services are optional in Medicaid, but both California and New Jersey have chosen to include them in their Medicaid state plans and their new adult ABPs, along with the option for beneficiaries to self-direct these services. As with any other Medicaid service, Susan will have to meet each state's medical

necessity criteria to qualify for personal care services. In addition, in California, Susan also will have to meet the medically frail criteria to qualify for personal care services in the new adult ABP. California's Medicaid program also covers attendant care services and supports through the ACA's new Community First Choice state plan option. Once Susan transitions to Marketplace coverage, personal care services are not included in either state's benchmark QHP, although both cover home health care services. (Tables 4 and 8)

PROVIDER NETWORKS

- **Provider networks may differ between Medicaid and Marketplace coverage.** Medicaid beneficiaries are limited to the providers who choose to participate in a state's Medicaid program, while QHP enrollees are limited to the providers included in the plan's network.

EXAMPLE: SUSAN, JOHN, AND MARY'S EXPERIENCES

Susan, John, and Mary all will need to see a primary care doctor for preventive care as well as specialists (an orthopedist for Susan, a psychiatrist for John, and a neurologist for Mary). In Medicaid, they will be limited to the providers who choose to participate in each state's program, and in the Marketplace, they will be limited to the network of physicians covered by the QHP that they select. If it is important for Susan to remain with the same orthopedist who has cared for her throughout her life, then she will want to choose a QHP in which that physician participates. John and Mary also will want to consider which providers participate in each QHP's network when selecting a plan.

COST-SHARING

- **Beneficiaries are likely to experience higher out-of-pocket costs in Marketplace QHPs than in Medicaid.** Premiums are generally not permitted in Medicaid for people with incomes below 150% FPL. None of the states used in this analysis included premiums for people above 150% FPL or deductibles, and some included limited co-payments in their Medicaid programs. By contrast, Marketplace QHP enrollees with incomes between 100-133% FPL will have premium costs of 2% of income in 2014, as well as deductibles, co-insurance, and/or co-payments; those from 133-150% FPL will have premium costs of 3% of income in 2014. While Marketplace cost-sharing reductions contribute to making coverage more affordable, as illustrated in Kentucky, the deductibles and co-payments in QHPs still exceed the limits in Medicaid. In addition, Marketplace premium and cost-sharing amounts vary among states, as the ACA allows variation based on geographic region.

EXAMPLE: SUSAN'S POTENTIAL EXPERIENCE IN CALIFORNIA AND NEW JERSEY

Medicaid premiums and cost-sharing are imposed at state option, and it does not appear that Susan will be subject to any out-of-pocket costs when she is covered by the Medicaid state plan or the new adult ABP in California or New Jersey. (Tables 5 and 9)

When Susan transitions to Marketplace coverage, her income will have increased, but her out-of-pocket health care costs will increase as well. Marketplace plans have premiums that are limited to 2% of enrollee income for those from 100-133% FPL and 3% of income for those from 133-150% FPL in 2014. Pursuant to the ACA's community rating provision, plans can vary premiums based only on age, geographic area, tobacco use, and number of family members. In the QHP selected for this analysis, Susan will pay \$108 per month in premiums and receive a premium subsidy of \$137 per month if she is earning 145% FPL. California has chosen to

standardize cost-sharing amounts for all Marketplace plans in the same metal tier. For the representative California silver level plan used in this analysis, Susan will have an annual deductible of \$1,500 for medical services and \$250 for prescription drugs, and her out-of-pocket costs will be capped at \$5,200. She also will have co-payments, such as \$40 for a primary care visit, \$50 for a specialist visit, and \$19 for a generic drug. These amounts include the ACA's cost-sharing reductions. (Table 5)

Premiums and cost-sharing vary among QHPs in New Jersey's FFM. In the representative QHP selected for this analysis, with earnings of 145% FPL, Susan will have monthly premiums of \$48 and qualify for a premium subsidy of \$256 per month. She also would have a \$100 annual deductible, with out-of-pocket costs limited to \$750. And, she would have co-payments, such as \$15 for a primary care visit and \$30 for a specialist visit after her deductible is met, and \$7 for a generic drug. These amounts include the ACA's cost-sharing reductions. (Table 9)

EXAMPLE: JOHN'S POTENTIAL EXPERIENCE IN OHIO

Like Susan, John's out-of-pocket costs will vary depending on his coverage source. Ohio's Medicaid program has co-payments for prescription drugs (\$3 for non-preferred drugs and \$2 for selected single-source drugs) that apply in its Medicaid state plan and new adult ABP.

When John transitions to Marketplace coverage in Ohio, he will have additional out-of-pocket costs. The representative QHP in Ohio has an annual deductible of \$100, with an out-of-pocket maximum of \$2,250. After the plan deductible is met, primary care and specialists visits are subject to 5% coinsurance, and there are \$5 co-payments for generic drugs. At 145% FPL, John would have monthly QHP premiums of \$49, with a premium subsidy of \$186 in Ohio. These amounts include the ACA's cost-sharing reductions. (Table 11)

EXAMPLE: MARY'S POTENTIAL EXPERIENCE IN KENTUCKY

As in other states, Mary's out-of-pocket costs will differ as she moves between Medicaid and Marketplace coverage in Kentucky. Kentucky's Medicaid program does not charge premiums, but it does include co-payments for certain services under both its state plan and the new adult ABP. For example, Mary would have to pay \$3 for a doctor's office visit or a physical therapy session, \$1 for generic drugs, \$4 for preferred brand-name drugs, and \$8 for non-preferred brand name drugs.

Once Mary transitions to a Marketplace QHP in Kentucky, she would qualify for cost-sharing reductions with her income of 145% FPL. The information available about Kentucky's representative QHP illustrates the significant role that the ACA's cost-sharing reductions play in helping make Marketplace coverage more affordable for people with incomes between 100-250% FPL. For example, Mary's annual deductible in the representative Kentucky QHP in 2014 is \$200 with cost-sharing reductions but \$2,500 without cost-sharing reductions. Similarly, her out-of-pocket maximum is \$600 with cost-sharing reductions but \$6,350 without cost-sharing reductions. Mary's co-payments for certain services also would vary in the representative Kentucky QHP with and without cost-sharing reductions. For example, with cost-sharing reductions, a primary care doctor's visit has a \$10 co-payment for the first three visits, which are not subject to the deductible. After the deductible is met, Mary's co-insurance is 10% for additional visits. Without cost-sharing reductions, the co-payment for the first three doctor's visits is \$40. Generic drug co-payments are \$10 with cost-sharing reductions and \$15 without cost-sharing reductions. (Table 7)

Looking Ahead

Medicaid is likely to remain an important source of coverage for working people with disabilities, and the ACA's Medicaid expansion and new Marketplace QHPs will provide greater access to affordable coverage for this population across the income spectrum. Given the state flexibilities provided in federal law, there is wide variation in Medicaid benefits and cost-sharing across states. Because of the additional flexibility that states have in designing their new adult ABPs, working people with disabilities who are covered as newly eligible adults may experience some changes in their benefits and cost-sharing if they move between different Medicaid coverage groups due to changes in their income and/or their health status (i.e., medical frailty). Most states have chosen to minimize any differences, but where they exist, newly eligible adults might have broader mental health and substance use treatment coverage and more limited LTSS coverage than other Medicaid adults in their state. Differences in benefits and cost-sharing are likely to be more significant when working people with disabilities move between Medicaid and Marketplace coverage, given the different rules that apply to each program. Understanding how these differences may affect working people with diverse disabilities can help inform future policy-making related to benefits and cost-sharing under the ACA's new coverage options.

Appendix 1

Table 4: Selected Benefits Covered Through Medicaid and the Marketplace in California

Benefit Type	Medicaid State Plan	Medicaid New Adult ABP	Marketplace QHP
Mental health and substance use treatment services	<ul style="list-style-type: none"> -Outpatient mental health, including individual and group evaluation and therapy, psychological testing, outpatient monitoring of drug therapy, labs, drugs, supplies, supplements, screening and brief intervention, psychiatric consultation for medication management -Outpatient heroin detox services -Other licensed practitioners (psychologists) -Rehab services, including mental health services, medication support, day treatment intensive, day rehab, crisis intervention, crisis stabilization, adult residential treatment, crisis residential, and psychiatric health facility services 	Same as state plan	<ul style="list-style-type: none"> -Inpatient psychiatric hospitalization and intensive psychiatric treatment programs -Substance abuse disorder inpatient detox -Mental/behavioral health outpatient services* for diagnosis and treatment -Substance abuse disorder outpatient services, including day treatment, intensive outpatient, individual and group counseling, and medical treatment for withdrawal symptoms
Prescription drugs	Covered	Same as state plan	Generic, preferred brand, non-preferred brand, and specialty drugs
Rehabilitative and habilitative services and devices	<ul style="list-style-type: none"> -Durable medical equipment (prior authorized) -Medical supplies -Prosthetic and orthotic appliances -Physical, occupational and speech therapy and audiology -Outpatient rehab center services -Specialized rehab services in skilled nursing and intermediate care facilities -Skilled nursing facility (90 days) 	Same as state plan	<ul style="list-style-type: none"> -Skilled nursing facility (100 days/year) -Outpatient rehab services, including physical, occupational and speech therapy -Habilitation services* -Durable medical equipment (prior authorized)
Long-term services and supports	<ul style="list-style-type: none"> -Community Based Adult Services -Case management/targeted case management -Home health services – skilled nursing, home health aide, physical, occupational and speech therapy and audiology, and medical social work services -ICF/DD -Multipurpose Senior Services Program -Personal care services, including self-direction -Skilled nursing facility (over 90 days) -Private duty nursing -Community First Choice attendant care services and supports 	Same as state plan (beneficiary must meet medically frail criteria to access LTSS)	-Home health care services (100 visits/year, up to 2 hours/visit, 3 visits/day; nurse, master’s level social worker, physical/occupational/speech therapist)

NOTES: *State required benefits (outpatient mental health coverage for severe mental illness, hab services for behavioral health treatment of autism and related disorders).

SOURCES: CA state Medicaid plan benefits information from CA § 1115 Bridge to Reform Demonstration Special Terms and Conditions, available at <http://www.dhcs.ca.gov/provgovpart/pages/waiverrenewal.aspx>; CA New Adult ABP, SPA#CA-13-035, available at www.medicaid.gov; QHP coverage based on Marketplace EHB benchmark plan, Kaiser Foundation Health Plan Small Group HMO 30 ID, and state required benefits, available at www.cms.gov/CCIIO/Resources/ehb.html.

Table 5: Cost-Sharing in Medicaid and the Marketplace in California

Cost-Sharing Type	Medicaid State Plan	Medicaid New Adult ABP	Marketplace QHP
Monthly premiums	0	Same as state plan	\$108 with APTC (\$245 without APTC; APTC = \$137)
Annual Deductible	N/A	Same as state plan	\$1,500 medical; \$250 brand Rx
Out-of-pocket maximum	Per federal law, cost-sharing shall not exceed 5% of total family income (\$201/quarter, or \$804/year, for an individual based on quarterly earnings of 138% FPL)	Same as state plan	\$5,200
Co-pays for selected services	N/A	Same as state plan	-\$40 primary care physician visit -\$50 specialist visit -\$19 generic Rx -\$250 ER

NOTES: CA QHP information based on single, non-smoker, age 35, 145% FPL (\$1,388/month), L.A. County, www.healthcare.gov.

SOURCES: State Medicaid Plan information available at

<http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx>; APTC based on KFF subsidy calculator, <http://kff.org/interactive/subsidy-calculator/>; CSR for Health Net Enhanced Silver 73 HMO available at www.healthcare.gov.

Table 6: Selected Benefits Covered Through Medicaid and the Marketplace in Kentucky

Benefit Type	Medicaid State Plan*	Medicaid New Adult ABP	Marketplace QHP**
Mental health and substance use treatment services	<ul style="list-style-type: none"> -Inpatient mental health services (prior authorization; no IMD services for 21-64) -Outpatient psychiatric services (4/year unless rendered by board-eligible or board-certified psychiatrist) -Mental health center services -Preventive chronic disease services for depression -Screening, assessment, and psychological testing -Crisis intervention, mobile crisis and residential crisis stabilization -Peer and parent/family support -Individual and group outpatient therapy (3 hours/day each, exceed if medically necessary) -Family outpatient therapy -Intensive outpatient services and partial hospitalization -Substance use disorder screening, brief intervention, referral, residential services, medication assisted treatment -Mental health assertive community treatment, comprehensive community support services, and therapeutic rehabilitative program -Service planning and case management -For those under age 21, collateral outpatient therapy and day treatment 	Same as state plan	<ul style="list-style-type: none"> -Mental/behavioral health and substance abuse disorder inpatient services (30 days/ for mental health and substance use combined; 2 inpatient and outpatient substance abuse rehab programs per lifetime) -Mental/behavioral health and substance abuse disorder outpatient services (30 visits/year for mental health and substance use combined) <p>The above services include partial day mental health and substance abuse services, intensive outpatient programs, and residential treatment services.</p>
Prescription drugs	Provided (subject to preferred drug list, may require prior authorization)	Same as state plan	Generic, preferred brand, non-preferred brand, and specialty drugs
Rehabilitative and habilitative services and devices	<ul style="list-style-type: none"> -Durable medical equipment, medical supplies, prosthetics and orthotics (some exclusions, some items subject to prior authorization) -Nursing facility (90 day rehab stay) -Physical, occupational, and speech therapy (prior authorization, combined 20 inpatient and outpatient visits per type of therapy per year including both rehab and hab, prior authorization for medically necessary additional visits) 	Same as state plan	<ul style="list-style-type: none"> -Durable medical equipment, devices, supplies, prosthetics and appliances (some exclusions) -Skilled nursing facility services (90 days/year) -Rehab facilities (60 days/year) -Outpatient rehab and hab services, including physical, occupational, speech, pulmonary, and cardiac rehab therapy (20 visits per type of therapy per year, including both rehab and hab*** for physical, occupational and speech therapy, except 36 visits/year for cardiac rehab)
Long-term services and supports	<ul style="list-style-type: none"> -Long-term care nursing facility services (must meet criteria for “high intensity,” “low intensity” or ICF/IDD, prior authorization, re-evaluated every 6 months) -Home health services, including intermittent or part-time nursing (prior authorization, includes disposable medical supplies) and home health aide services (prior authorization) -Private duty nursing (up to 2,000 hours per year with prior authorization, exceed if medically necessary) 	Same as state plan	<ul style="list-style-type: none"> -Home health care services*** (100 visits/year, including nurse, therapist, home health aide, and physical, occupational, and speech therapy) -Private duty nursing (2,000 hours/year)

NOTES and SOURCES: *KY uses an ABP for currently eligible beneficiaries (SPA#KY-13-021); KY State Medicaid Plan, available at <http://chfs.ky.gov/dms/State+Plan+Amendments.htm>; KY New Adult ABP, SPA#KY-13-020, available at www.medicaid.gov. **QHP coverage based on Marketplace EHB benchmark plan, Anthem BCBS Blue 6 Blue Access PPO Medical Option D4 Rx Option G and state required benefits, available at www.cms.gov/CCIIO/Resources/ehb.html; ***KY state required benefit. (Hab services required for autism spectrum disorders).

Table 7: Cost-Sharing in Medicaid and the Marketplace in Kentucky

Cost-Sharing Type	Medicaid State Plan	Medicaid New Adult ABP	Marketplace QHP
Monthly premiums	0	Same as state plan	\$117 with APTC (\$262 without APTC; APTC = \$145)
Annual Deductible	N/A	Same as state plan	\$200 with CSR (\$2,500 without CSR)
Out-of-pocket maximum	Cost-sharing shall not exceed 5% of total family income for a quarter (\$201/quarter, or \$804/year, for an individual based on quarterly earnings of 138% FPL)	Same as state plan	\$600/year including deductible with CSR (\$6,350 without CSR)
Co-pays for selected services	<ul style="list-style-type: none"> - \$50.00 per inpatient hospital admission - \$4.00 for outpatient hospital services - \$3.00 for physician services/office visits with physical and behavioral health providers - \$1.00 for preferred and non-preferred generic drugs and atypical anti-psychotics without generic equivalent - \$4.00 for preferred brand name drugs without generic equivalent and available under supplemental rebate program - \$8.00 for non-preferred brand name drugs - \$3.00 per visit for physical, occupational and speech therapy - \$4.00 per date of service for durable medical equipment <p>Preventive services are not subject to co-pays Certain populations are exempt from Medicaid cost-sharing under federal law</p>	Same as state plan	<ul style="list-style-type: none"> - \$10 primary care physician visit with CSR, not subject to deductible for 1st 3 visits, 10% after deductible for additional visits (\$40 without CSR, 1st 3 visits subject to co-pay, additional visits subject to deductible and 10% coinsurance after deductible) - 10% after deductible for specialist visit with CSR (same without CSR) - \$10 not subject to deductible for generic drugs with CSR (\$15 without CSR) - \$75, then deductible and 10% for emergency room visit with CSR (\$200 copay before deductible without CSR)

NOTES: KY QHP information based on single, non-smoker, age 35, 145% FPL (\$1,388/month), Jefferson County, Kynect, <https://kyenroll.ky.gov/PreScreening/PreScreeningOverView>.

SOURCES: KY State Medicaid Plan, available at <http://chfs.ky.gov/dms/State+Plan+Amendments.htm>; APTC based on KFF subsidy calculator, <http://kff.org/interactive/subsidy-calculator/>; CSR for Anthem BCBS Silver DirectAccess PPO – dbds, available at <https://www.anthem.com/health-insurance/kentucky/health-plans/>.

Table 8: Selected Benefits Covered Through Medicaid and the Marketplace in New Jersey

Benefit Type	Medicaid State Plan	Medicaid New Adult ABP	Marketplace QHP
Mental health and substance use treatment services	<ul style="list-style-type: none"> -Mental health rehab, inpatient, and outpatient services -Inpatient and outpatient substance use services -Mental health clinic services -Methadone maintenance -Partial care -Partial hospitalization -Inpatient psych under 21/over 65 -Residential treatment center -Case management -Personal care services for mental health (25 hours/week) 	<ul style="list-style-type: none"> -Inpatient mental health and psychiatric services -Inpatient hospital medical detox -Non-hospital based detox (including individual and group counseling) -Outpatient substance use disorder services (including intake, assessment, physician services, individual, group and family counseling) -Substance use partial care (including physician services, lab, individual, group and family counseling), -Substance use intensive outpatient (including physician services, individual, group, and family counseling) -Substance use short-term residential (including individual, group, and family therapy) -Partial hospitalization -Outpatient hospital and clinic mental health services -Community support services -Program of assertive community treatment services -Case management -Community mental health rehab services, including psychiatric emergency rehab -Behavioral health home services -Opioid treatment/maintenance -Mental health adult rehab (group homes) 	<ul style="list-style-type: none"> -Mental/behavioral health and substance abuse disorder inpatient services (prior authorized) -Mental/behavioral health and substance abuse disorder outpatient services <p>Substance abuse disorder inpatient and outpatient treatment of alcoholism and coverage of biologically based mental illness are state required benefits</p>
Prescription drugs	Covered	Same as state plan	Generic, preferred brand, non-preferred brand, and specialty drugs
Rehabilitative and habilitative services and devices	<ul style="list-style-type: none"> -Durable medical equipment -Rehab services (60 consecutive days/year) -Rehab hospital services -Medical supplies Orthotics Prosthetics -Outpatient rehab, including physical, occupational and speech therapy 	<ul style="list-style-type: none"> -Physical, occupational, and speech therapy – rehab and hab (prior authorization) -Home-based habilitative services (§ 1915(i)) -Prosthetics (prior authorization above certain dollar amounts) 	<ul style="list-style-type: none"> -Outpatient rehab (30 visits/year, prior authorized) -Speech and cognitive therapy (30 visits/year – rehab and hab) -Physical and occupational therapy (30 visits/year – rehab and hab) -Durable medical equipment* (prior authorized) -Autism/DD hab and rehab services* – physical, occupational, and speech therapy (30 visits/year) and applied behavioral analysis (under age 21)
Long-term services and supports	<ul style="list-style-type: none"> -Home health services -ICF/DD -Medical day care -Nursing facility services -Personal care services -Private duty nursing (prior authorization) -Respite care -Skilled nursing facility 	<ul style="list-style-type: none"> -Home health services, including nursing, home health aide, medical supplies, equipment, and appliances for home and physical, occupational, and speech therapy -Clinic services - medical day care (12 hours/day, prior authorized) -Adult day health services (§ 1915(i)) -Personal care services, including self-direction (40 hours/week) -Nursing facility/skilled nursing facility services (prior authorized) 	<ul style="list-style-type: none"> -Home health care services* (60 visits/year, prior authorized, includes private duty nursing and supplies) -Skilled nursing facility (prior authorized)

NOTES/SOURCES: * = state required benefit. State plan benefits information: CMS Special Terms and Conditions, NJ Comprehensive Waiver Demonstration, Attachment B, Demonstration Benefits, Plan A (Oct. 1, 2012-June 30, 2017) (http://www.state.nj.us/humanservices/dmahs/home/CMW_STCs.pdf). NJ New Adult ABP (SPA#13-0028), (www.medicaid.gov). QHP coverage based on Marketplace EHB benchmark plan, Horizon HMO Access HSA Compatible and state required benefits (www.cms.gov/CCIIO/Resources/ehb.html).

Table 9: Cost-Sharing in Medicaid and the Marketplace in New Jersey

Cost-Sharing Type	Medicaid State Plan	Medicaid New Adult ABP	Marketplace QHP
Monthly premiums	None	Same as state plan	\$48 with APTC (\$304 without APTC; APTC = \$256)
Annual Deductible	N/A	Same as state plan	\$100
Out-of-pocket maximum	N/A	Same as state plan	\$750
Co-pays for selected services	None	Same as state plan	- \$15 primary care physician visit after deductible - \$30 specialist visit after deductible - \$7 generic drug - \$65 ER visit after deductible

NOTES: NJ QHP information based on single, non-smoker, age 35, 145% FPL (\$1,388/month), Bergen County, www.healthcare.gov.

SOURCES: NJ State Medicaid Plan A information available at <http://www.njfamilycare.org/income.aspx>; APTC based on KFF subsidy calculator, <http://kff.org/interactive/subsidy-calculator/>; CSR for AmeriHealth NJ Tier 1 Advantage Silver EPO H.S.A., available at www.healthcare.gov.

Table 10: Selected Benefits Covered Through Medicaid and the Marketplace in Ohio

Benefit Type	Medicaid State Plan	Medicaid New Adult ABP	Marketplace QHP
Mental health and substance use treatment services	<ul style="list-style-type: none"> -Inpatient hospital services (including by psychologists; no IMD services for 21-64) -Licensed psychologist services (specified procedures; in non-hospital setting, psychological testing limited to 8 hours/year and therapeutic visits and diagnostic interviews limited to combined 25 service dates/year; diagnostic interview limited to 1 per beneficiary/ year) -Advanced practice nurses' services (includes psychiatric clinical nurse specialists) -Clinic services, including FFS ambulatory health care clinics for behavioral health -Rehabilitative services provided by community mental health facilities, including: <ul style="list-style-type: none"> --behavioral health counseling and therapy (52 hours/year) --mental health assessment services (4 hours/year if by non-physician and 2 hours/year if by physician) --pharmacologic management services (24 hours/year) --partial hospitalization (minimum 2 hours and up to maximum 16 hours/day) --crisis intervention mental health services --community psychiatric supportive treatment (104 hours/year; additional hours if medically necessary and prior authorized) -Rehabilitative services provided by alcohol and other drug treatment programs, including: <ul style="list-style-type: none"> --ambulatory detoxification --assessment --crisis intervention --group counseling* --individual counseling* --intensive outpatient services --laboratory urinalysis --medical/somatic services* (such as physical examinations, health assessments, vital signs, reviewing lab findings, medication administration services, medication assisted treatment and dispensing of medications in an alcohol or other drug treatment program) -- opioid agonist administration * Group counseling, individual counseling and medical/somatic services limited to 30 cumulative hours/person/week -Health home services for beneficiaries with a serious mental health condition (available in certain counties, provided by community behavioral health centers), including comprehensive care management, care coordination, health promotion services, comprehensive transitional care services (from inpatient to other settings), individual and family support services, referral to community and social support services -Case management services for people with chronic mental illness and beneficiaries receiving alcohol or substance use disorder treatment program services 	<p>Same as state plan, except that quantitative limits on mental health outpatient services, alcohol and drug intensive outpatient services, and psychologist services do not apply</p>	<ul style="list-style-type: none"> -Mental/behavioral health and substance abuse disorder inpatient services (30 days/year combined for non-biologically based mental illness*) -Mental/behavioral health and substance use disorder outpatient services (30 visits/year combined for non-biologically based mental illness*) <p>These services include partial day and intensive outpatient programs, 2 days of which are equivalent to 1 day inpatient. Substance abuse disorder services limited to 2 inpatient and outpatient rehab programs/year for non-biologically based mental illness. *Biologically based mental illness is covered the same as any other medical service.</p>

Prescription drugs	Provided (subject to preferred drug list, may require prior authorization)	Same as state plan	Generic, preferred brand, non-preferred brand, and specialty drugs
Rehabilitative and habilitative services and devices	<ul style="list-style-type: none"> -Clinic services, including outpatient rehab and speech-language/audiology clinics -Prosthetic devices (require authorization) -Medical supplies, equipment, and appliances suitable for use in the home (some items require prior authorization) -Physical, occupational, and speech therapy/audiology services (30 visits/year per service type in a non-institutional setting, additional visits prior authorized); -Mechanotherapy services (massage therapy; includes treatment services but not maintenance services) 	Same as state plan	<ul style="list-style-type: none"> -Skilled nursing facility (90 days/year) -Rehab facilities (60 days/year) -Outpatient rehab (physical, occupational, speech, pulmonary and cardiac rehab; 20 visits/year for each type, except 36 visits for cardiac) -Durable medical equipment, devices, supplies, prosthetics, and appliances (some exclusions)
Long-term services and supports	<ul style="list-style-type: none"> -Nursing facility services (requires level of care) -ICF/IDD services (requires level of care) -Home health services, including intermittent or part-time nursing and home health aide services (limited to combined 8 hours/day together with physical, occupational, and speech therapy and audiology; each service type shall not exceed 4 hours/visit; intermittent or part-time nursing and home health aide services limited to combined 14 hours/week; additional services authorized if medically necessary) -Private duty nursing,* including <ul style="list-style-type: none"> --skilled care post-hospital services up to 56 hours/week during 60 days after discharge from a 3 day or more inpatient stay (excludes maintenance care) --services for beneficiaries up to age 21 with authorization --services for beneficiaries age 21 and older with authorization who require continuous nursing, including ongoing maintenance care and where beneficiary requires level of care comparable to an institution * PDN visits are typically more than 4 but less than or equal to 12 hours; must be 2 or more hour lapse between home health intermittent or part-time nursing services and PDN, except for unusual occasional circumstance requiring up to 16 hour visit, or if less than 2 hour lapse and the length of PDN services requires the agency to provide a change in staff, or where the PDN service is provided by more than one non-agency provider, or if PDN visits are authorized for 4 hours or less -Case management services for people with developmental disabilities 	Same as state plan	<ul style="list-style-type: none"> -Home health care services, including nurse, therapist, home health aide, physical, occupational, and speech therapy (100 visits/year) -Private duty nursing (\$50,000/year; \$100,000/lifetime)

SOURCES: OH State Medicaid Plan, available at <http://medicaid.ohio.gov/MEDICAID101/MedicaidStatePlan.aspx>; APTC; OH New Adult ABP (SPA#13-0032), available at www.medicare.gov; QHP coverage based on Marketplace EHB benchmark plan, Blue 6 Blue Access PPO Medical Option D4 Rx Option G, and state required benefits summary, available at www.cms.gov/CCIIO/Resources/ehb.html.

Table 11: Cost-Sharing in Medicaid and the Marketplace in Ohio

Cost-Sharing Type	Medicaid State Plan	Medicaid New Adult ABP	Marketplace QHP
Monthly premiums	0	Same as state plan	\$49 with APTC (\$235 w/o APTC; APTC = \$186)
Annual Deductible	N/A	Same as state plan	\$100
Out-of-pocket maximum	Per federal law, cost-sharing shall not exceed 5% of total family income (\$201/quarter, or \$804/year, for an individual based on quarterly earnings of 138% FPL)	Same as state plan	\$2,250
Co-pays for selected services	- \$3.00 for prescription drugs not on preferred list - \$2.00 for selected single-source prescription drugs	Same as state plan	- Primary care doctor, specialists, and ER visits: 5% coinsurance after deductible - Generic prescription drugs: \$5 copay after deductible

NOTES: OH QHP information based on single, non-smoker, age 35, 145% FPL (\$1,388/month), Cuyahoga County, www.healthcare.gov. QHP cost-sharing reflects cost-sharing reduction subsidies.

SOURCES: OH State Medicaid Plan, available at <http://medicaid.ohio.gov/MEDICAID101/MedicaidStatePlan.aspx>; APTC based on KFF subsidy calculator, <http://kff.org/interactive/subsidy-calculator/>; CSR for Kaiser Foundation Health Plan Silver 1750/25%/H.S.A., available at www.healthcare.gov.

Appendix 2

Methodology for Selecting Representative QHPs for Cost-Sharing Analysis

Differences among states in terms of both Marketplace design choices and readily available public sources of information about Marketplace coverage led to slight differences in the methodology used to select the QHP in each state for purposes of the cost-sharing analysis. A silver level plan offered in 2014, in the county with the largest population in each state was selected, as that is the metal tier to which premium subsidies are tied. Specifically, the representative QHP was selected from the plans available for a single, 40 year old, non-smoker, with income at 145% FPL.

California has chosen to be an active purchaser in its state-based Marketplace and has standardized deductibles, out-of-pocket maximums, and co-payments for all QHPs in each metal tier. As a result, the silver level plan with the least expensive premium was selected for California. New Jersey and Ohio are both FFM states, and the silver plan with the least expensive premium was selected in each of these states.

Kentucky has a state-based Marketplace and as of spring 2014, did not provide information about premium tax credit or cost-sharing reduction amounts when presenting QHP information on its website. The Kaiser Family Foundation's subsidy calculator was used to determine premium tax credit amounts for this analysis in Kentucky. Among the three insurers offering silver level plans in the county with the largest population in Kentucky in 2014, only one provided cost-sharing reduction information on the insurer's own website. While there were plans with less expensive premiums for purchase in Kentucky, no cost-sharing reduction information for these plans was readily available. Among the five silver plans (offered by the same issuer) with cost-sharing information available, the plan with the second least expensive premium was selected as representative. This was due to differences in how cost-sharing is structured in the selected plan as compared to the plan with the least expensive premium. Specifically, the selected plan covers some services, such as three doctor's visits and prescription drugs, with just a co-payment, without the need to first meet a deductible, while the plan with the least expensive premium for which cost-sharing reduction information was available applies the deductible to all covered services.

Appendix 3

HYPOTHETICAL 1: SUSAN, AGE 21, DIAGNOSED WITH MILD CEREBRAL PALSY (CP)

EDUCATION AND WORK HISTORY: After graduating from high school, Susan enrolled in a local community college. She received her Associate's degree and then transferred to a four-year college to complete her Bachelor's degree. At that point, she moved out of her parents' house to attend school and live on her own.

While attending community college, Susan worked as a cashier at a retail clothing store in a local mall. She worked 25 hours per week, earning \$8.25 per hour, with annual earnings of \$10,725, or about 92% of the federal poverty level for a single adult in 2014. She continued this job during her junior year of college to cover her living expenses and tuition costs that were not covered by grants and student loans.

In her senior year of college, Susan was offered a job as a bookkeeper. She continued working 25 hours per week, but earned \$13 per hour in her new job, with annual earnings of \$16,900, or approximately 145% FPL in 2014.

HEALTH INSURANCE COVERAGE: While living with her parents, Susan was covered under a family health insurance policy that her parents purchased in the individual market, and her parents paid out-of-pocket for all of her disability-related expenses that were not covered by the policy. Susan's parents now receive employer-sponsored health insurance through their respective jobs. Neither of their policies offers coverage for dependent family members, so Susan was unable to maintain coverage through her parents' insurance.

Susan's state expanded Medicaid as of January 2014. While working as a cashier, Susan qualified for Medicaid as a newly eligible adult with earnings below 138% FPL. When she changed jobs and started working as a bookkeeper, Susan became eligible for Marketplace coverage with premium tax credits and cost-sharing reductions.

HEALTH HISTORY: Susan's needs for acute physical health and preventive services are the same as those of other, healthy young adults. She also has some additional medical needs associated with her CP diagnosis. A common symptom of CP is paralysis, which varies significantly across individuals. Susan is able to walk but uses crutches or a power scooter when she travels significant distances, including getting around campus. She takes prescription medication to control muscle spasticity, which is a common condition secondary to CP. The muscle spasticity results in lack of fine motor control, which makes brushing her teeth difficult, and she also has dental issues related to tooth grinding, another complication of muscle spasticity. Because her vision is affected by her CP, she wears prescription eyeglasses.

Susan receives physical therapy twice a month to manage contractures stemming from muscle spasticity. Her physician believes she would benefit from weekly physical therapy and monthly occupational therapy to improve her fine motor skills. However, her coverage for these services was limited to 20 visits per year under her family's health insurance policy, so she has not received more frequent visits. Since she is relatively young, she has not yet experienced additional complications from her abnormal gait, but she is at risk for developing

chronic joint pain and degeneration from the additional strain on her legs due to her gait and on her shoulders due to long-term use of crutches, which could require additional physical therapy.

Because Susan's fine motor skills are mildly impaired, her family sometimes helped her button or tie clothing, prepare meals and do laundry. Susan had no plan for seeking assistance with these needs when she went away to college, so they will likely be unmet, or performed to the best of her ability, without formal personal care services in place.

While she is not currently in treatment for mental health issues, Susan was bullied in school because of her gait and use of crutches. She may have undiagnosed mild depression and/or anxiety as a result and might benefit from mental health diagnostic services, and if warranted, treatment.

HYPOTHETICAL 2: JOHN, AGE 35, DIAGNOSED WITH CLINICAL DEPRESSION

EDUCATION AND WORK HISTORY: John is a high school graduate with a limited work history as a day laborer for a local construction company. The company has employed John seasonally, and in three of the last five years, he earned approximately \$15,000 per year, or about 129% FPL for a single adult in 2014. In two of the last five years, due to the economic downturn and bad weather, John's earnings have been as low as \$9,000 per year, or about 77% FPL in 2014.

John was recently offered a year-round job as an assistant to an auto mechanic. The position pays \$8.15/hour for a 40-hour work week. If he takes this job, John would make \$16,952 a year, or about 145% FPL in 2014. John prefers working outdoors and feels better when he is not inside all day, but the consistent schedule and regular pay offered by the auto mechanic job is appealing to him.

HEALTH INSURANCE COVERAGE: None of John's past jobs have offered health insurance, and as a single adult without dependent children, he did not qualify for Medicaid before his state implemented the ACA's Medicaid expansion in January 2014. Based on his current earnings of 129% FPL, he is eligible for Medicaid in 2014. If he accepts the auto mechanic job, John will become eligible for Marketplace coverage with premium tax credits and cost-sharing reductions.

HEALTH HISTORY: John was first diagnosed with depression after a failed suicide attempt at age 32 when he was taken to the emergency department and involuntarily committed to inpatient treatment. The hospital released him after 72 hours of observation when the psychiatric staff determined that he was no longer a danger to himself.

John needs regular doctor appointments and takes a prescription anti-depressant medication. When he was uninsured (prior to becoming eligible for Medicaid through the expansion), John was unable to take his medication consistently, because it is expensive for him to afford out-of-pocket. John's doctor has encouraged him to seek individual and group therapy, but he has been unable to follow up on this recommendation because he was uninsured and unable to pay out-of-pocket.

While uninsured, John visited the doctor when he is physically ill and paid out-of-pocket when he had the resources. Otherwise, his health care-related expenses went unmet. He also could benefit from regular preventive health care services.

HYPOTHETICAL 3: MARY, AGE 40, DIAGNOSED WITH MULTIPLE SCLEROSIS (MS)

EDUCATION AND WORK HISTORY: Mary finished high school but never went to college. She recently divorced and has no children. She currently rents a two-bedroom apartment with a friend. Most of her jobs have been in food preparation, and she currently works at a fast-food restaurant. Mary works 30 hours a week at \$8.25 per hour, with annual earnings of approximately \$12,870, or about 110% FPL for a single adult in 2014. She has not been able to find full-time work.

Mary recently began looking for a second job since her current employer is unable to give her any additional hours. She decided to take a job selling tickets at a movie theater on the weekends, where she will earn \$8.50 per hour. She will work 9 hours per week, earning \$3,978 per year and bringing her total annual income to \$16,848, or nearly 145% FPL in 2014.

HEALTH INSURANCE COVERAGE: Mary has been uninsured all of her adult life. When she recently was admitted to the hospital, a social worker helped her apply for health insurance. Because her state implemented the ACA's expansion, she is eligible for Medicaid while she is working at the fast-food restaurant. However, once Mary takes her second job, she will become eligible for Marketplace coverage with tax credits and cost-sharing reductions.

HEALTH HISTORY: Mary's lack of health insurance and limited income have made it difficult for her to afford basic preventive health care, such as annual physical examinations. She only seeks medical care when the need is critical, and she does not have a regular primary care provider.

In January 2014, she visited the emergency department after experiencing an extended bout of blurred vision and muscle weakness. She previously noticed these symptoms, but they typically lasted less than a day. With recurring symptoms and a marked reduction in her ability to lift her left arm, Mary decided to seek medical care. She was admitted to the hospital for additional evaluation, including a visit from a neurologist. During the hospital stay, the neurologist conducted a battery of tests, including an MRI. Although her symptoms resolved by the time she was released from the hospital, the tests revealed that she had multiple sclerosis, and the neurologist gave her the formal diagnosis.

After her discharge, she followed up with the neurologist as an outpatient. The neurologist recommended that she begin receiving regular doses of an injectable drug to slow the progression of the disease. He also referred her to a physical therapist for regular treatment of her muscular weakness and ordered some additional tests to assess the extent of impairment in her vision and fine motor functioning.

Mary does not currently need assistance with activities of daily living as her symptoms of muscle weakness and blurred vision typically do not interfere with her ability to work and take care of herself at home. However, if her symptoms worsen, they are likely to interfere with her ability to continue to work.

Endnotes

¹ U.S. Dep't of Labor, Bureau of Labor Statistics, Persons with a Disability: Labor Force Characteristics Summary, Table A (June 11, 2014) (includes non-institutionalized people ages 16-64), available at <http://www.bls.gov/news.release/disabl.nro.htm>.

² Social Security Administration, The Work Site, Ticket Program Information, available at <http://www.ssa.gov/work/home.html>.

³ U.S. Dep't of Labor, Office of Disability Employment Policy, Job Accommodation Network, Vocational Rehabilitation Agencies, available at <http://askjan.org/cgi-win/TypeQuery.exe?902>.

⁴ Kaiser Commission on Medicaid and the Uninsured, *The Affordable Care Act's Impact on Medicaid Eligibility, Enrollment, and Benefits for People with Disabilities* (April 2014), available at <http://kff.org/health-reform/issue-brief/the-affordable-care-acts-impact-on-medicaid-eligibility-enrollment-and-benefits-for-people-with-disabilities/>.

⁵ Kaiser Commission on Medicaid and the Uninsured, *A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion* (Aug. 2012), available at <http://kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-decision/>.

⁶ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options* (Jan. 2012), available at <http://kff.org/medicaid/issue-brief/medicaid-enrollment-and-expenditures-by-federal-core/>.

⁷ 42 U.S.C. § 1396a(k)(1); 42 C.F.R. §§ 440.300-440.390.

⁸ Kaiser Commission on Medicaid and the Uninsured, *Premiums and Cost-Sharing in Medicaid* (Feb. 2013), available at <http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid/>; see also 42 C.F.R. §§ 447.50-447.88.

⁹ Kaiser Family Foundation Subsidy Calculator, available at <http://kff.org/interactive/subsidy-calculator/>.